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M E M O R A N D U M

TO: Legislative Audit Committee Members

FROM: Jim Pellegrini, Deputy Legislative Auditor, Performance Audits

DATE: March 30, 2000

RE: **Follow-up to Performance Audit:**
Medicaid In-Home Services Programs
Department of Public Health and Human Services (98P-01)

INTRODUCTION

In December 1998, we presented our performance audit on Medicaid In-Home Services Programs to the Legislative Audit Committee. The report made 15 recommendations to the Department of Public Health and Human Services (DPHHS). We requested and received information from DPHHS on their progress in implementing the recommendations in January 2000. To complete the follow-up project, we interviewed department officials and staff and reviewed changes to written policies and procedures, provider manuals, and provider education tapes.

SUMMARY OF FOLLOW-UP RESULTS

As can be seen in the following table, the department implemented the majority of the recommendations. The recommendation which has not been implemented relates to billing for home health services in 15-minute increments. The department is awaiting further information currently being gathered by the federal Health Care Financing Administration (HCFA) on the feasibility of implementing 15-minute billing increments for Medicare before proceeding with this recommendation for Medicaid services.

Implementation Status	
Implemented	10
Being Implemented	1
Partially Implemented	3
Not Implemented	1
Total	15

BACKGROUND OF IN-HOME SERVICES PROGRAMS.

Montana Medicaid recipients receive care in their homes for health needs resulting from diseases such as multiple sclerosis, cerebral palsy, chronic obstructive disease, or congestive heart failure. Three programs provide the majority of publicly funded in-home health services: the Home Health Program, the Personal Assistance Services Program, and the Home and Community Based Services Program.

The Home Health Program provides for skilled nursing services, physical therapy, speech therapy, and occupational therapy services. Recipients receive help with activities of daily living such as dressing and grooming, household tasks, and escort services from the Personal Assistance Services Program. The Home and Community Based Services Program provides an array of services including case management,

traumatic brain injury services, and private duty nursing. Recipients can receive services from one program or a combination of services from the three programs. The programs are administered by the Community Services Bureau, Department of Public Health and Human Services.

The federal Health Care Financing Administration oversees the Montana Medicaid program and issues guidelines and directives relating to the program. Approximately 70 percent of Montana Medicaid program expenditures are federally funded. The state provides the remaining 30 percent as a match to the federal funds.

FOLLOW-UP FINDINGS

The following sections give the implementation status of each recommendation based on follow-up work performed by the Legislative Audit Division.

Ensure Home Health Caregivers Receive Program Policies and Procedures Manual

During our audit we found some home health agency personnel did not see the policies and procedures manual for the program and were unaware of specific requirements for the Medicaid Home Health Program. The Medicaid fiscal intermediary, a private company contracted to process provider Medicaid payments, sends the manuals to home health agencies. We found a number of the home health agency personnel were not aware of the manual for the Home Health Program because it also contained billing information and was kept by the billing personnel of the agencies.

Prior Recommendation #1

We recommend the Community Services Bureau ensure home health caregivers receive the program policies and procedures manual.

This recommendation is implemented.

The bureau developed a new provider manual for the Home Health Program and issued it to all Medicaid home health providers.

Rules, Policies, and Procedures Outlining Written Plan of Care Requirements

Under state Medicaid requirements, home health agencies are required to develop a written plan of care outlining the recipient's treatment. Our review of recipient charts showed poor documentation of the written plans of care. We noted program staff had not developed administrative rules, policies, or procedures defining who is the attending physician, allowing physicians to verbally approve the plan of care prior to the start of treatment, or requiring attending physician signatures on the written plan of care before the start of treatment.

Prior Recommendation #2

We recommend the bureau develop rules, policies, and procedures outlining written plan of care requirements for:
-prescribing physicians,
-physician's signatures,
-dates, and
-verbal orders.

This recommendation is implemented.

The bureau developed needed policies, and procedures outlining written plan of care requirements including those discussed above.

Compliance Reviews and Provider Education Program Needed

Testing showed providers do not understand and follow program requirements. A compliance review process over Medicaid home health would help ensure providers comply with program requirements. A provider education program would help ensure providers and their employees are aware of requirements specific to the Medicaid Home Health Program and when home health services are appropriate.

Prior Recommendation #3

We recommend the bureau:

A. Implement a compliance review process for home health providers.

B. Develop a provider education program for home health providers.

This recommendation is implemented.

Bureau staff negotiated a contract with a private company to conduct yearly reviews of home health providers, which includes determining if services provided to recipients are medically necessary. Staff also implemented a provider education program.

Home Health Reimbursements Based on Length of Time Provider Spends in Home

Using information gathered from recipients, we determined the program could save Medicaid funds by reimbursing providers based on the length of the home health visit. Providers are reimbursed by the visit so providers spending 15 minutes with the recipient are paid the same as providers working with recipients for an hour.

Prior Recommendation #4

We recommend the bureau consider a cost per unit of service reimbursement for home health payments.

This recommendation is not implemented.

As discussed above, the bureau is awaiting a decision from the federal level concerning reimbursing home health providers based on the length of the home health visit before proceeding with this recommendation.

Medication Management

As part of the home health chart review we determined 36 percent of the recipients primarily received medication management for prescription drugs. Medication management consists of a nurse coming into the recipient's home to fill a medication box. Other recipients having diabetes require insulin syringes prefilled by the nurse. Prior to our audit, the bureau identified medication management as a service which could be provided in a more cost-effective manner.

Prior Recommendation #5

We recommend the Medicaid program implement alternative methods for delivering medications, including insulin, in a more cost-effective manner.

This recommendation is being implemented.

The bureau drafted a policy on an alternative method for delivering medications to recipients. For insulin they determined nurses could predraw syringes for up to two weeks which reduces the number of home health visits.

Services for Developmentally Disabled Recipients

Seventeen percent of the recipients in our sample were developmentally disabled. The Montana Medicaid program has a separate waiver for developmentally disabled recipients. The waiver gives the department authority to develop a comprehensive program for treatment of developmentally disabled clients. This

authority includes providing private duty nursing services to recipients at a significant cost savings over having home health agencies provide the services.

Prior Recommendation #6

We recommend the bureau and the Developmentally Disabled Program develop the most cost-effective method of delivering home health services to developmentally disabled recipients.

This recommendation is implemented.

The bureau transferred a portion of their appropriation authority to the Developmentally Disabled Program to allow implementation of a comprehensive program for providing chronic nursing care to recipients.

Personal Assistance Weekly Limits

The Personal Assistance Program allows a recipient to receive up to 40 hours of personal assistance services a week. Additional hours can be provided in excess of this amount with written department authorization. We found 7 of 39 recipients received services in excess of the weekly Personal Assistance Program limit without prior authorization from the bureau. The Medicaid Management Information System (MMIS) is used to process personal assistance claims. Programming currently allows providers to submit claims for overlapping periods.

Prior Recommendation #7

We recommend the bureau:

A. Require providers to submit claims for personal assistance services covering a week time period.

B. Establish a limit parameter on the MMIS which would identify billings submitted in excess of the weekly limits for personal assistance services.

C. Include a review of personal assistance claims to ensure providers do not bill for overlapping weeks during provider compliance reviews.

This recommendation is partially implemented.

The bureau reviewed the cost of implementing weekly parameter limits on the MMIS and found it would be cost prohibitive to change the programming. Staff attempted a monthly parameter but found it did not identify inappropriate claims. The bureau included a review of overlapping bills in changes to their compliance review process.

Self-Directed Health Maintenance Elections

Recipients of personal assistance services can participate in the Self-Directed Personnel Assistance Services Program. Included in the program is the option of having the personal attendant provide health maintenance activities such as wound care, medication management, and bowel and bladder programs. In our sample, three recipients elected to have their self-directed personal attendant perform one or more health maintenance tasks. After this election was made, the recipients' conditions changed and they needed a home health agency to perform the tasks. The recipients did not change their plans of care to reflect the change in their conditions, nor did they change their election to have health maintenance activities performed by their self-directed attendant. This resulted in the Medicaid program paying for the recipients' health maintenance activities twice.

Prior Recommendation #8

We recommend the bureau:

A. Provide Medicaid self-directed personal assistance service recipients clarification and education relating to amendments to plans of care if their condition changes.

B. Review both self-directed assistance services and home health services provided to recipients during compliance reviews.

This recommendation is implemented.
The bureau provided training to self-directed personal assistance service recipients and included review of these services and home health services during their compliance reviews.

Consistency in Compliance Reviews
Regional program officers perform annual compliance reviews of all personal assistance providers. The officers review a sample of recipient charts to determine if providers are in compliance with program requirements. Compliance is determined based on providers meeting standards outlined for the program. During testing of compliance reviews completed by regional program officers, we found the final determination of whether a standard was met, met with comments, or not met did not always agree with the information gathered from the chart reviews.

Prior Recommendation #9
We recommend the bureau establish procedures to ensure the determination of whether a personal assistance provider met standards is based on the results of the charts reviewed.

This recommendation is implemented.
The bureau revised the compliance review process to ensure consistency with standard measurements. They provided training to regional program officers and updated their desk manual to include the procedures.

Home Visit Information Not Consistent
In addition to chart reviews, regional program officers are to conduct home visits on a sample of personal assistance services recipients. During a home visit the officer interviews the recipient to determine if the recipient is receiving services, if there is any problem with the services, and if the officer can assist the recipient in any way. We determined regional program officers did not consistently gather the same type of information. We also determined the officers did not always retain the records of home visits after they completed the provider's final compliance review report.

Prior Recommendation #10
We recommend the bureau:
A. Implement a home visit process which ensures regional program officers obtain the same information when conducting the reviews.
B. *Ensure regional program officers retain records of home visits.*
C. Periodically, review worksheets used in provider compliance reviews to determine if officers have followed bureau procedures relating to home visits.

This recommendation is implemented.
The bureau included standardized home visit questions with requirements on record retention in the desk manual for regional program officers. In addition, the program managers for all three programs now periodically review the work completed by regional program officers.

Home and Community Services Waiting List
The Medicaid program was granted a waiver by HCFA for the Home and Community Based Program. The waiver allows Medicaid recipients to receive individually prescribed and arranged services according to their needs. This service area is not an entitlement and the number of persons serviced is constrained by the funds appropriated by the Montana legislature. When all funds are committed, eligible individuals are placed on a waiting list until resources become available. We determined 21 of the 72 recipients on

the waiting list as of June 30, 1998, resided in nursing homes. We calculated the Medicaid program could save between $74,964 and $196,761 by providing adult residential services under the waiver program for the 21 eligible recipients residing in nursing homes.

Prior Recommendation #11

We recommend:

A. *The legislature include language to allow the department to transfer appropriation authority between Medicaid programs.*

B. *The department appropriately transfer Medicaid funds into the waiver program to reduce nursing home expenditures.*

This recommendation is implemented.

The bureau submitted the proposal; however, the legislature did not include language to allow the department to transfer appropriation authority between Medicaid programs in the General Appropriations Act. The bureau is currently tracking information on recipients transferring from one service setting to another.

Home Visits Made by Case Management Teams

Bureau policy requires case management teams to make home visits of recipients on the waiting list to receive home and community based services. The purpose of the visits is to assess the recipient's medical stability, mobility, independence, judgment, and adequacy of current placement. The information gathered is used to prioritize the recipient's need for services and determine the next recipient to receive services when funding becomes available. Some care management teams did not complete home visits.

Prior Recommendation #12

We recommend the bureau include home visit documentation in the compliance review process of home and community based waiver providers.

This recommendation is implemented.

The bureau included home visit documentation as a component of their compliance review process for home and community based waiver providers.

Rules for Traumatic Brain Injured Recipients

The bureau did not have rules relating to traumatic brain injury services provided under the waiver program. Section 2-4-201, MCA, requires all state agencies to adopt rules setting forth the nature and requirements of all formal and informal procedures.

Prior Recommendation #13

We recommend the bureau implement rules for traumatic brain injury services provided under the Home and Community Based Services Program.

This recommendation is implemented.

Home and Community Services Program rules were filed with the Secretary of State on January 14, 2000.

Sampling Using Statistical Tools and Extrapolation

The bureau conducts provider compliance reviews on personal assistance providers. Regional program officers determine if providers are in compliance by reviewing a two-week span rather than a statistical sample of services provided during the entire year. By expanding the compliance review process of each provider to include the use of statistical samples of all expenditures made to that provider in a fiscal year, the bureau ensures providers comply with program requirements for the entire year and not just for a two-week period. It would also require providers to repay all funds to which they are not entitled.

Prior Recommendation #14

We recommend the bureau develop a statistical sampling approach to identify in-home service providers' overpayments for the year under review.

This recommendation is partially implemented.
The bureau uses their compliance review process to identify providers with utilization issues. When they find problems with providers they refer them to the Quality Assurance Division, which utilizes a statistical sampling process to assess overpayments.

Copayment Calculations

DPHHS adopted rules requiring recipients to pay their Medicaid services provider $2 per service for home health and $0.50 per service for durable medical equipment and medical supplies. We found MMIS does not calculate the copayment for durable medical equipment and medical supplies in accordance with the rule.

Prior Recommendation #15

We recommend the department ensure the computer calculation and Medicaid publications for copayments are in compliance with section 46.12.204, ARM.

This recommendation is partially implemented.
The bureau revised the Medicaid publication for copayments to be consistent with the computer calculation. The Health and Policy Services Division is responsible for revising the rule to be consistent with the computer calculation. This has not yet been completed.